CHAPTER OVERVIEW

This chapter will discuss policy and procedure for placing children with resource families and/or in a residential treatment facility.

5.1 Placement in a Resource Family

When a child is needing placement in a resource family, the Children's Service Worker/Case Manager will obtain a court order or an authorization to detain the child and then prepare the resource for placement, providing all available information about the child. When a child is to be in care for less than two (2) weeks prior to an adoptive placement, obtain a completed SS-44 from the foster family.

Related Subject: Chapter 27, of this section, Permanency Through Adoption.

To prepare the child for placement, the Children's Service Worker will provide the child with information about the resource family. The worker will help with the trauma of separation, re-enforcing the belief that the child is not the cause of the family breakdown. The child will also need help to understand the reasons the parents/caretakers cannot care for him/her. For youth, age 13 – 21, assure the child that they will be directly involved in long term planning and will be expected to maintain personal responsibility for their actions.

NOTE: Youth, ages 13-21 shall receive a copy of "What's It All About?" A Guidebook for Teens in Out-of-Home Care, and shall be referred to the appropriate program, CHOICES or CFCIP.

The Children's Service Worker will arrange pre-placement visits, and arrange to obtain a medical examination and medical history. The medical examination should include an HIV screening (ELISA test) for children displaying symptoms of AIDS or AIDS Related Complex (ARC) or at high risk of HIV exposure.

Children at risk of HIV infection include:

- Hemophiliacs or those children who received blood transfusions prior to 1985;

- Intravenous (IV) drug users;
- Infants born to a mother who tests HIV positive;
- Children with one or both parents who have tested HIV positive, have ARC, AIDS, or is at high risk for AIDS;
- Sexually active youth who have had a sexual contact with a high risk individual or an HIV infected individual; and
- Subjects of sexual abuse where the perpetrator is at high risk of AIDS or is an HIV infected individual.

If the Children's Service Worker is unable to obtain the initial medical exam prior to placement, the initial medical examination shall occur, if possible, within 24 hours of the child coming into care. If a provider is not readily accessible, this exam must occur within ten (10) days of the initial placement.

The needs of the child should always be foremost in deciding how soon the exam must take place. If the child has obvious medical needs, or is coming from an environment where a physical exam is indicated, the exam must take place as soon as possible.

The Children's Service Worker shall also arrange to meet the cost of care expenses.

The worker/case manager will utilize the team approach to determine the most appropriate resource family for a child who tests HIV positive. Team members should include:

- The child's physician;
- Public health personnel;
- The child's parent or caretaker;
- Case manager;
- The potential resource family provider, i.e., foster parent, adoptive parent, residential care provider;
- The child (age 13 or older); and,
- Residential licensing representative, if appropriate.

NOTE: The team may need to meet at regular intervals to assess the child's health status and the appropriateness of the placement setting.

NOTE: A child placed in an out-of-home care setting has a right to privacy. This right is necessary to protect the child. Only those persons directly responsible for the child's care or defined as a person with the need to know (see statute 191.650 - 191.695) should be informed of his/her condition.

Related Subject: Chapter 11, of this section, Financial Support Planning.

NOTE: Report immediately any accidental injuries to a child in our custody, and who is a Medicaid recipient, using procedures in the Income Maintenance Manual, Chapter VII.

After transporting the child to the resource family, the Children's Service Worker will confirm or clarify any information previously shared. The worker will also provide full and accurate medical information (current condition and history) to the resource provider using form CW-103. If none or only part of the above is known, share what is available and continue obtaining needed medical history. If the child has tested HIV positive, provide complete information for caring for the child's special medical needs and infection control.

If the resource family is a kinship provider, the Children's Service Worker should provide them with the following information at the time of placement:

1. A copy of the CS-33;

2. A Medicaid form and instructions for obtaining a complete health examination;

3. Procedures for obtaining clothing for the child;

4. The name and phone number of the child's current school and instructions to enroll the child in a new school, if needed; and

5. The name and 24-hour contact telephone numbers of the worker and supervisor.

The Children's Service Worker will assist the resource family or other resource provider with the initial adjustment of the child. Follow the placement with a visit to the resource family, kinship family, or foster family group home the next day to do an assessment of the initial adjustment. Determine if any assistance is needed. Contact any other out-of-home care resource within five (5) working days if another resource type has been selected.

The Children's Service Worker must contact the parents to continue formulating a treatment plan. Set up a visit between the birth parent(s) and child within the first week of placement. Visitation shall not take place in a home where a known or suspected methamphetamine laboratory exists or has existed unless it has been professionally

treated or decontaminated by a hazardous waste cleanup agency according to the guidelines of the Environmental Protection Agency (EPA). An alternate location for the visit must be decided upon.

The Children's Service Worker will complete the necessary placement forms (SS-6l, CW-104, CW-105) and set up a record for the child, separate from parent's record. Using information from Section 4, Chapter 11, the worker will also complete and submit all cost of care forms.

All placement activities will need to be recorded by the Children's Service Worker within ten (10) working days. The progress of the placement and treatment plan will be recorded every 30 days thereafter. The social worker will also provide a written report to the court which will include the identification of the resource family or other resource care provider and information regarding placement activities. Furthermore, the worker will participate in any court hearings.

5.2 Placement in a Residential Treatment Facility

This placement resource should be considered for children who need structured and therapeutic intervention provided in a residential treatment setting.

Related Subject: Chapter 18.2, in this section, Residential Treatment Referral.

Related Subject: Chapter 4.4.9, in this section, Residential Treatment.

5.2.1 Indicators of Treatment Needs in Children Age 0-6

Residential treatment services for a child(ren) under the age of seven (7) years are not usually recommended or utilized. However, certain behavior conditions can exist which would indicate need for a structured treatment setting for such a child. In most instances, it is preferable that foster family care be selected. Referrals using these indicators can be made for behavioral (where available) or medical foster care. These indicators must be used as guidelines in assessing whether a referral for such services is to be made to the RCST.

1. Physical Handicaps/Medical Problems:

   Acute or chronic physical/medical problems which require nursing or specialized caregiving skills on a frequent and regular basis in order to maintain, control, or remediate problem(s) such as:

   A. Infants

      1) Failure to thrive: difficulties in feeding, slow weight gain, discrepancy in height/weight, malnourishment.

2) Feeding difficulties: may be seen as resistance to food, does not eat effectively or remains fussy after adequate amount of feeding - no pleasurable relief.

3) Fetal alcohol syndrome: withdrawal symptoms, physiological and neurological disturbances.

4) Premature birth: may result in serious respiratory problems, seizures, etc.

B. Other conditions for any 0-6 year old child

1) Physical trauma: fractures, subdural hematomas

2) Cerebral palsy necessitating use of "range of motion" exercises, physical therapy, etc.

3) Seizure disorders

4) Casts, wheelchairs

2. Developmental Level:

Delayed development in one or more areas of basic skills essential to readiness for the tasks required in normal daily living such as:

A. Motor skills (gross and fine)

Specific skills vary according to age but observation can detect a disturbance in progressive mastery of tasks requiring muscle tone and control (sitting, crawling, standing, jumping, etc.) and coordination.

B. Cognitive skills

Specific skills vary according to age but observation and testing can detect a disturbance in object relatedness, perception and response to environmental stimuli (internal and external, task readiness).

C. Self-help skills

Specific skills vary according to age but are characterized by difficulties in caring for self (dressing, eating) and interacting with others (play, separation).

3. Speech/Language:

   Delays in the development of speech or language, or a problem (physical/emotional) which impairs the ability to use or respond to verbal communication such as:

   A. Expressive

      1) No babbling by six (6) or seven (7) months of age

      2) No attempts at simple words by 12 months

      3) No attempts at simple sentences by 24 months

      4) Speech difficult to understand after three (3) years of age

   B. Receptive

      1) Not localizing to sound of voice by six (6) months

      2) Not responding to simple requests (say "bye-bye") by 12 months

      3) Not recognizing common objects by name (i.e., "show me the ball") by 24 months

      4) Not understanding long and complex sentences or unable to carry out two (2) to three (3) commands by three (3) years

   C. Any significant disparity between expressive and receptive language skills.

4. Emotional Adjustment: Difficulties

   A. 0 to 1 year

      1) Poor sucking - no medical reason

      2) Poor and infrequent eye contact, not molding to body of parent or substitutes after six (6) months

      3) Not exploring environment

      4) Does not look to one person to be special/primary to them (i.e., bonding)

      5) No sign of separation trauma/stranger anxiety

B. 1 to 3 years

Not seeking some autonomy/independence from adults

C. 2 to 3 years

1) Having long temper tantrums

2) Showing aggression towards peers and adults

3) Not following simple clear instructions (i.e., being defiant, ignoring)

4) Regular night terrors, nightmares

D. 3 to 6 years

1) Inability to occupy self for short period of time

2) Not curious or experimental

3) No role model assumed

4) Not engaging in social play

5) Not toilet trained

6) No imaginary play

7) Manipulative behaviors - lying, hoarding, overeating

8) Excessive fears, phobias

9) Possessions more important than people

10) Clinging/dependency

11) Role-reversals with adults

12) Consistent questioning "Do you like me?" "Are you my friend"

13) Repeated rigid body movements

14) Not talking

15) No risk taking

16) Rocking

5. Sexual Adjustment:

   Inappropriate sexual behavior which may result from sexual abuse or be symptomatic of emotional/psychological problems such as:

   - Frequent masturbation
   - Fear of going to sleep
   - Frequent exposure of genitals
   - Seeking genital contact with others
   - Cross-sex dressing
   - Provocative sexual behavior

6. Relationship within Family Setting:

   Cannot accept close familial relationships or cannot function in a family setting.

7. Aggression as a Problem:

   Random purposeless aggression, poor impulse control, attention-getting aggression, purposeful (aimed at serious hurting) such as aggression, biting or scratching, aggression against peers, adults - aggression against self.

8. Background Factors:

   A social history reflecting prolonged sexual abuse or malnourishment/failure to thrive, though these may not be the presenting problem; and experience with several placements, separation, or loss of caregivers, or experience with a non-bonding relationship.

5.2.2 Residential Treatment Referral

Related Subject: Chapter 18.2, of this section, Residential Treatment Referral.

5.3 Private Psychiatric Hospital Placements

Occasionally, it may be necessary to place a child who is in the custody of the Children's Division (CD) into a private psychiatric hospital or a general hospital which offers inpatient psychiatric services. Such a placement should be limited to situations where a child needs the diagnostic and treatment services that only a psychiatric hospital can provide. Staff is encouraged to use facilities which are contracted with CD. This is especially important if it is anticipated that the child's stay will exceed the Medicaid Professional Activity Study (PAS).

Medicaid provides payment for these placements based on a PAS determination. The number of days for which Medicaid will pay depends on the specific diagnosis. Each hospital should have a listing of the PAS for each distinct diagnosis or combination of diagnoses. The actual number of days paid by Medicaid will be determined by the discharge diagnosis. The hospital should be able to complete a preliminary diagnosis and estimate the number of days of stay within the first week.

The Area Director must be notified as soon as it appears a stay beyond the approved PAS will be necessary. It is the responsibility of the Area Director or RCST Coordinator to approve extra days.

The Children's Service Worker monitors the number of days a child is in a psychiatric facility. Near the end of the allowed length of stay, the worker contacts the facility to discuss the child's discharge plan. When a Medicaid eligible child is in need of a psychiatric inpatient extension that is medically necessary (versus no other placement available), the worker should request, with Area Office approval, that the facility seek prior approval of the extension through the Division of Medical Services (DMS) for DMS payment of the service. If DMS denies the extension, the facility should submit the invoice for payment to the CD county office. Such an invoice is forwarded through normal supervisory channels to the Program Development Systems Unit (PDSU). PDSU completes and enters form CS-65 in the Children's Services Integrated Payment System (CSIPS) to generate payment. A copy of the CS-65 form will be returned to the case manager county and the Area Director who approved the extension. Psychiatric hospital placement is considered a form of residential treatment and will be charged to the residential treatment appropriation.

It is necessary to monitor and evaluate the placement of children in a private psychiatric hospital. To do so effectively, the following procedures have been developed:

A. Prior to or upon placement of a child in a private psychiatric hospital, county staff shall:

    1. Attempt to utilize a hospital which has a contract with the Children's Division;

2. Request that the hospital provide, in writing, a treatment plan, diagnosis, and the expected length of stay within seven (7) calendar days of admittance;

3. Notify the Area Director, in writing, of the placement, including the reasons for this type of placement and expected length of stay;

4. Notify the hospital that the maximum length of stay shall be that of the PAS for this diagnosis unless approval is received from the Area Director;

5. Refer to the Area Office, any child(ren) placed in a private psychiatric hospital, where long-term residential treatment services (RTS) is anticipated.

B. During the child's stay in the hospital, county staff shall:

1. Develop a control system to indicate the maximum stay approved by the PAS;

2. Make plans to move the child no later than the PAS deadline, unless the Area Director approves an extension;

3. Notify the Area Director, via a report requesting an extension, as soon as the length of stay is expected to exceed the PAS. Approval for extension shall only be authorized by the Area Director. The following information should be included in the report:

a) A description of the efforts made to secure an alternate placement;

b) A copy of the hospital's diagnosis and recommended treatment;

c) An explanation of the continued need for care at the psychiatric facility; and,

d) An indication, if appropriate, that a referral has been made to the area office for residential treatment services (RTS) or Department of Mental Health, or if transfer of custody is planned;

4. Request the hospital seek prior approval of the extension through DMS for extended Medicaid payment of the service. The hospital should request DMS to notify the CD county office of the decision.

5. If DMS approved the extension, request the hospital invoice DMS to determine the amount to be paid through Medicaid.

6. If DMS denied the extension, request the hospital to invoice the county office. Send the invoice, through normal supervisory channels, to PDSU.

7. As soon as possible, forward to the area office the hospital diagnosis indicating continued need for psychiatric care. The area office will utilize this material in attempting to obtain an appropriate alternate placement.

8. For children whose diagnosis indicates a need for long-term treatment in a psychiatric or other facility, assess whether continued CD custody is appropriate.

Related Subject: Chapter 13, of this section, Replacement of the Child With Another Provider

Related Subject: Section 7, Chapter 12, Developmental and Psychological Problems; and Section 7, Chapter 15, Department of Mental Health.

C. If a child is approved for continued treatment in a psychiatric facility, the Area Director shall:

1. Notify the county of the decision regarding approval for child to remain in the facility prior to expiration of the PAS days;

2. Notify the Deputy Director of Children's Services of children approved for inpatient psychiatric hospitalization past the PAS end date. This notification will include:

   a) Child's DCN number;

   b) Current location of child; and,

   c) An explanation of the continued need for treatment at the psychiatric facility.

MEMORANDA HISTORY: